The Costello Center
8081 38th Ave N., St. Petersburg, FL 33710
Phone: 727-345-2667 Fax: 727-209-2667
www.thecostellocenter.com

CLIENT DATA FORM – CHILD/ADOLESCENT

A. Basic Information

Child/Adolescent's Name: _____ **Date:** _____

Date of Birth: _____ **Gender** _____ **Race/Ethnicity** _____

Address: _____ **Phone:** _____
Street **City** **State** **Zip Code**

Family

Mother: _____ **Age:** _____ **Marital Status:** _____

Phone: _____ **May we leave a message?** ☐ **Yes** ☐ **No**

Address (if different than child's): _____
Street **City** **State** **Zip Code**

May we mail to your home? ☐ **Yes** ☐ **No** **Email Address:** _____

Place of Employment: _____ **Occupation:** _____

Work Phone: _____ **Highest Degree Earned:** _____

Father: _____ **Age:** _____ **Marital Status:** _____

Phone: _____ **May we leave a message?** ☐ **Yes** ☐ **No**

Address (if different than child's): _____
Street **City** **State** **Zip Code**

May we mail to your home? ☐ **Yes** ☐ **No** **Email Address:** _____

Place of Employment: _____ **Occupation:** _____

Work Phone: _____ **Highest Degree Earned:** _____

Who has legal custody? ☐ **Mom** ☐ **Dad** ☐ **Joint** ☐ **Other, please specify:** _____

Other Persons Living in Your Household (names, dates of birth, and relationship to you)

Name:	**Relationship**	**DOB**	**Other Information that May be Relevant**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is your relationship to the client? _____ **If not the Mother/Father, please complete the following:**

Name: _____ **Phone:** _____ **May we leave a message?** ☐ **Yes** ☐ **No**

Address (if different than child's): _____
Street **City** **State** **Zip Code**

May we mail to your home? ☐ **Yes** ☐ **No** **Email Address:** _____

How did you hear about The Costello Center? ☐ Website ☐ Referred by: _____
☐ Other: _____

Who is the appointment with today? _____

Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse patient. (42 C.F.R. 2.32)

The Costello Center
8081 38th Ave N., St. Petersburg, FL 33710
Phone: 727-345-2667 Fax: 727-209-2667
www.thecostellocenter.com

B. Medical History

Primary Care Physician: _____ Phone Number: _____
Pregnancy and Birth History: ☐ Full term ☐ Premature ☐ Adopted, please specify: _____
_____
Please list any unusual circumstances during the first five years (separation/divorce, illness in family, deaths, etc.):
_____
_____
Serious Medical Illnesses/Accidents (Identify and give dates): _____
_____
_____
Does your child/adolescent have a history of infectious diseases? ☐Yes ☐ No If yes, please describe:_____
_____
Does your child/adolescent have any allergies? ☐ Yes ☐ No If yes, please describe: _____
_____
Is your child/adolescent currently taking medications? ☐ Yes ☐ No If yes, please list: _____
_____
Has your child/adolescent taken prescribed medications in the past? ☐ Yes ☐ No If yes, please list: _____
_____
Surgeries or operations (Identify and give dates): _____
_____
Any hospitalizations? ☐ Yes ☐ No If yes, please list date and reason: _____
_____
Has your child/adolescent had previous counseling? ☐ Yes ☐ No If yes, with whom and when? _____
_____
Is or has your child/adolescent been under the care of a psychiatrist? ☐ Yes ☐ No If yes, with whom and when?
_____

C. Primary reason for visit today:

_____
_____

Check any that apply to you, and circle those that are the most significant:

__Abuse
__Addictions
__Substance Use/Abuse *(tobacco, alcohol, illegal/prescription drugs)*
__ADHD symptoms
__Anxiety symptoms
__Anger or irritability
__Changes in mood
__Obsessive thoughts
__Worry or guilt
__Lying
__Adjustments *(Changing schools, parent's getting married or divorced, pet died, new job, job loss, etc.)*
__Bad dreams/nightmares
__Sleeping difficulties
__Bed wetting
__Career decisions
__Learning disability
__Learning/academic difficulties
__Personal growth
__Relationship problem
__Parent-child relationship problem
__Non-family relationship problem *(teacher, peers, etc.)*
__Chronic illness
__Eating problem
__Sexual concerns
__Cutting/Self-injurious behavior
__Sadness or depressive symptoms
__Suicidal thinking
__Other:_____

Parent (Custodial/Non-Custodial/Guardian) Signature: _____ Date:

Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse patient. (42 C.F.R. 2.32)

The Costello Center
8081 38th Ave N., St. Petersburg, FL 33710
Phone: 727-345-2667 Fax: 727-209-2667
www.thecostellocenter.com

Client General Information Form

Part A. Emergency Contact Information

_____ _____
Full Name (Please Print) Relationship

_____ _____
Home phone Cell/work phone

_____ _____
Full Name (Please Print) Relationship

_____ _____
Home phone Cell/work phone

Part B. Academic Information (if applicable)

Current School: _____ Grade: _____ GPA: _____ Were you referred by the school?

Yes No

Are there any problems at school? ☐ Yes ☐ No If yes, please describe: _____

_____

Part C. Payment Information

Person responsible for session payments: _____ Phone Contact: _____

I authorize that my credit card may be kept on file: ☐ Yes ☐ No _____
(Initials)

Credit/Debit Card Information:

Card Type: ☐ Visa ☐ MasterCard

Card Number: _____

Expiration Date: _____ V Code (3 digits on back of card):_____

Name on Card: _____

Billing Address: _____

Phone Number: _____

I agree to pay for all services that I or the above client receives at The Costello Center.

_____ _____
Signature Date

Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse patient. (42 C.F.R. 2.32)

The Costello Center
8081 38th Ave N., St. Petersburg, FL 33710
Phone: 727-345-2667 Fax: 727-209-2667
www.thecostellocenter.com

☐ Kim E. Costello, Psy.D., LMHC, DAPA, BCPC, CEDS ☐ Carolyn McNulty*, LMHC, GAL ☐ Michelle L. Donley*, LCSW ☐ Rachel Agustines*, MD
☐ Alison Fuhr*, ARNP ☐ Kim Hughes*, LMHC, LPC, NCC ☐ Heather Bishop*, LMHC ☐ Lindsay Harrison*, LMHC☐ Allison Boutwell*, LCSW
☐ JuliAnn Marzuola*, LDN, LMHC ☐ Travis McNulty*, Registered Mental Health Intern ☐ Jennifer Lagergren*, Psychometrist, Registered Mental Health Intern
☐ Candice Lindsey, PAS ☐ Jessica Stanton, MSW ☐ The Costello Center ☐ Other:_____

PARENTAL CONSENT FOR TREATMENT OF A MINOR

Child's Name: _____ Date of Birth: _____

I consent on behalf of the minor child named above to seek counseling, psychotherapy, psychological assessment, psychiatric care, and/or other services from the The Costello Center and the providers selected above.

I hereby represent that I have legal authority to obtain medical treatment and/or counseling for the minor child for whom I am requesting treatment. I am a biological parent or legal guardian. If divorced, I have decision-making authority and can secure treatment without the authorization of the other parent.

I understand that communication between a client and clinician are confidential and protected by law. I also understand that exceptions include when a client is a danger to themselves or to others, or when there is a reasonable suspicion of child abuse.

This consent will be valid until the minor reached the age of 18, but may be revoked at any time with written notification.

Address of Parent/Guardian: _____ _____ _____ _____
Street **City** **State** **Zip Code**

Phone number of Parent/Guardian: _____ _____ _____
Home **Cell Phone** **Work**

_____
Print Name of Parent/Guardian

_____ _____
Signature of Parent/Guardian Date

Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse patient. (42 C.F.R. 2.32)

The Costello Center
8081 38th Ave N., St. Petersburg, FL 33710
Phone: 727-345-2667 Fax: 727-209-2667
www.thecostellocenter.com

NOTICE OF PRIVACY PRACTICES

☐ Kim E. Costello, Psy.D., LMHC, DAPA, BCPC, CEDS ☐ Carolyn McNulty*, LMHC, GAL ☐ Michelle L. Donley*, LCSW ☐ Rachel Agustines*, MD
☐ Alison Fuhr*, ARNP ☐ Kim Hughes*, LMHC, LPC, NCC ☐ Heather Bishop*, LMHC ☐ Lindsay Harrison*, LMHC☐ Allison Boutwell*, LCSW
☐ JuliAnn Marzuola*, LDN, LMHC ☐ Travis McNulty*, Registered Mental Health Intern ☐ Jennifer Lagergren*, Psychometrist, Registered Mental Health Intern
☐ Candice Lindsey, PAS ☐ Jessica Stanton, MSW ☐ The Costello Center ☐ Other:_____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by specific Federal and State Laws to protect your privacy. The *Health Information Portability and Accountability Act (HIPAA*) establishes rules on how your health information may be used and shared; and how it must be protected. We are obligated to follow the Florida Law when it is more protective of your privacy than the Federal Law.

Our pledge to you

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by TCC staff or an Independent Consultant.
We are required by law to:

- Keep medical information about you private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

This notice of Privacy Practices describes:

- How and to what extent the privacy of your Protected Health Information is guaranteed.
- How your Protected Health Information may be used and shared.
- How you may access portions of your Protected Health Information and the procedure for doing so.

Your Protected Health Information (PHI)

Your Protected Health Information includes any individual identifiable information created or received about you.
Specifically it includes:

1) Identification of symptoms, diagnosis, medicine, and your prognosis,
2) Appointment times and dates with session summaries, and
3) Payment for services provided and payment received. *Any notes taken during the session are classified in a separate category with their confidentiality protected so that you must give written permission to release them.*

Use and Disclosure of your Protected Health Information (PHI)

Without your specific consent:

- We will not share with your managed care company (insurance) or Employee Assistance Program, the PHI required to obtain approval for treatment and billing for services rendered.
- We will not share your PHI with another therapist or treatment facility.
- We will not share your PHI with another individual, including family members, except if the client is a minor.
- We are required to report child or elder abuse and/or neglect to the proper authorities. This report may include your PHI, if necessary.
- We are required to take action, including the release of your PHI, if we believe that you or someone else is in risk of harm to themselves or others.
- We may share your PHI with individuals or companies who participate in the management of our practice; each of these people has agreed to follow the terms of our Notice of Privacy Practices.
- We may release your PHI in case of a medical emergency to medical staff.

We may release your PHI <u>without your specific written consent</u> for these additional reasons:

Public Health	Patient Directories	Healthcare Oversight	When Required by Law
Health/Safety Activities	Law Enforcement	Workers' Compensation	
National Security	Judicial Proceedings	Coroner/Funeral Activities	
Military Activities	Correctional Facilities	Research	

Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse patient. (42 C.F.R. 2.32)

The Costello Center
8081 38th Ave N., St. Petersburg, FL 33710
Phone: 727-345-2667 Fax: 727-209-2667
www.thecostellocenter.com

NOTICE OF PRIVACY PRACTICES

Your Privacy Rights

You have the right:

- To decide with the exception of those listed above, if your PHI is given out to a third party and to specify what information is given. You do this by completing and signing the Consent Release Information. You may revoke this consent at any time.
- To review and get copies or your PHI. Your request must be in writing. There may be charges for copying and postage. Your request may be denied if it is determined that giving you your PHI may endanger your life or physical safety or that of another person.
- To request that corrections or additions be made to your PHI if you believe that there is an error or a significant omission. You or another health professional may add information to your record, but nothing will be removed from your PHI record. Under HIPAA rules, your request does not require a change of anything in your health records. However, if we deny your request, we will provide you with a written explanation. If we accept your request to change or add information, we will make reasonable efforts to tell others, including people you designate, of the change/addition in any future sharing of your PHI.
- To request additional limits on the use or disclosure of your PHI. However, as your provider, we are not required to agree to these additional limits if we have substantial reasons for not honoring your request.
- To request that we use a different way to speak with you in a confidential manner or to speak with you at a different location about your PHI.
- To obtain a list of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and other specific exceptions.
- To file a written complaint if you believe your privacy rights have been violated. Complaint can be submitted to the TCC Privacy Officer at 8081 38th Avenue North, St. Petersburg, Fl 33710, or to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201
  Your complaint must:
  1. Be filed in writing, either on paper or electronically, by mail, fax, or email;
  2. Name the covered entity involved and describe the acts or omissions you believe violated the requirements of the Privacy Rule;
  3. Be filed within 180 days of when you knew that the act or omission complained of occurred. OCR may extend the 180-day period if you can show "good cause."
- Your decision to file a complaint will not be held against you in any way. However, it may be necessary for us to discuss whether it is appropriate for us to continue in a therapeutic relationship.
- To receive a copy of this document upon request. *All requests must be made in writing to your therapeutic counselor.*

Our Legal Duty

We are required to agree to the terms of this notice. However, we reserve the right to change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law or to meet any new requirements implemented by law for the benefit of your PHI.

Before any important changes are made to the privacy practice, you will receive a revised notice that will be available to you on your first scheduled visit following the revisions. Any changes in these privacy practices and the new terms of this notice will take effect from the date of the revised forwarding of all mental health information we keep on file.

I have read and I understand all items contained herein.

_____	_____	_____
Client Name (print)	Client signature	Date

If a parent is signing on behalf of a client under 18, please sign below:

_____	_____	_____
Parent/Guardian Name (print)	Signature of Parent/Guardian	Date

***** *The Costello Center for Counseling and Academic Excellence includes Independent Consultants who are neither employees nor staff of The Costello Center but provide additional services for TCC clients.*

Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse patient. (42 C.F.R. 2.32)

The Costello Center
8081 38th Ave N., St. Petersburg, FL 33710
Phone: 727-345-2667 Fax: 727-209-2667
www.thecostellocenter.com

EMAILED INFORMED CONSENT

☐ Kim E. Costello, Psy.D., LMHC, DAPA, BCPC, CEDS ☐ Carolyn McNulty*, LMHC, GAL ☐ Michelle L. Donley*, LCSW ☐ Rachel Agustines*, MD
☐ Alison Fuhr*, ARNP ☐ Kim Hughes*, LMHC, LPC, NCC ☐ Heather Bishop*, LMHC ☐ Lindsay Harrison*, LMHC☐ Allison Boutwell*, LCSW
☐ JuliAnn Marzuola*, LDN, LMHC ☐ Travis McNulty*, Registered Mental Health Intern ☐ Jennifer Lagergren*, Psychometrist, Registered Mental Health Intern
☐ Candice Lindsey, PAS ☐ Jessica Stanton, MSW ☐ The Costello Center ☐ Other:_____

number of risks, both general and specific that clients need to be aware of if they choose this method of correspondence/counseling therapy.

A. General email risks include but are not limited to the following:

- Email can be immediately broadcasted worldwide and received by many intended and unintended recipients;
- Recipients can forward email messages to other recipients without the original sender's permission or knowledge;
- Users can easily send an e-mail to the incorrect address;
- Email is easier to falsify than handwritten or signed documents;
- Backup copies of email may exist even after the sender or the recipient has deleted his or her copy;
- Without the benefit of face-to-face interaction, emails can be misinterpreted in tone and meaning.

B. Specific email risks include but are not limited to the following:

- Email containing information pertaining to a client's diagnosis and/or treatment must be included in the client's medical records. Thus, all individuals who have access to the medical record will have access to the email messages
- If you are sending your emails from your employer's computer, your employer does have access to your emails.
- While it is against the law to discriminate and Florida subscribes to a "no cause" termination policy, an employer who has access to your email can use the information to discriminate against the employee. Additionally, the employee could suffer social stigma from a workplace disclosure.
- Insurance companies who learn of your PHI information could deny you coverage.
- Although counselors will endeavor to read and respond to email correspondence promptly, they cannot guarantee that any particular email message will be read and responded to within any particular time frame. The exception would be that the email is part of a scheduled time frame for a prepaid email counseling session.

C. Conditions for use of Email

All email messages sent or received that concern your diagnosis or treatment or that are part of your medical record will be treated as part of your PHI. Reasonable means will be used to protect the security and confidentiality of the email. Because of the risk outlined above the security and confidentiality of email cannot be guaranteed.

Your consent to email correspondence includes your understanding of the following conditions:

- All emails to and from you concerning your personal health information (PHI) will be a part of your file and can be viewed by health care and insurance providers and TCC office support staff.
- Your email messages may be forwarded within the center as necessary for diagnosis, treatment, and reimbursement. However, they will not be forwarded outside the office without your consent or as required by law.
- Though all efforts will be made to respond promptly this may not be the case. Because the response can not be guaranteed *please do not use email in a medical emergency.*
- You are responsible for following up with the counselor or support staff if you have not received a response.
- Medical information is sensitive and unauthorized disclosure can be damaging. You should not use email for communications concerning diagnosis or treatment of AIDS/HIV infection, other sexually transmissible diseases, mental health, and developmental disability or substance abuse issues.
- Since employers do not observe an employee's right to privacy in their email system, you should not use their employer's email system to transmit or receive confidential emails.
- The Costello Center will take reasonable steps to ensure that all information shared through emails is kept private and confidential. However, The Costello Center is not liable for improper disclosure of confidential information that is not a result of our negligence or misconduct.

The Costello Center
8081 38th Ave N., St. Petersburg, FL 33710
Phone: 727-345-2667 Fax: 727-209-2667
www.thecostellocenter.com

EMAIL INFORMED CONSENT

- If you consent to the use of email, you are responsible for informing your therapist of any type of information that you do not want sent to you by email other than the information detailed in Section B.
- You are responsible for protecting your password and access to your email account and any email you send or you receive from The Costello Center to ensure your confidentiality. Your therapist cannot be held liable if there is a breach of confidentiality caused by a breach in your account security.
- Any email that you send that discussed your diagnosis or treatment constitutes informed consent to the information being transmitted. If you wish to discontinue emailing information, you must submit written consent, by mail or in person at our center, informing your therapist that you are withdrawing consent to email information.

☐ Yes, I have read the above and consent to email correspondence

☐ No, I am not interested in email correspondence.

_____
Email Address

_____ _____
Print Name of Client Date

_____ _____
Client Signature Date

If parent is signing on behalf of a client under 18, please sign below:

_____
Print Name of Parent/Guardian

_____ _____
Signature of Parent/ Guardian Date

***** *The Costello Center for Counseling and Academic Excellence includes Independent Consultants who are neither employees nor staff of The Costello Center but provide additional services for TCC clients.*

Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse patient. (42 C.F.R. 2.32)

The Costello Center
8081 38th Ave N., St. Petersburg, FL 33710
Phone: 727-345-2667 Fax: 727-209-2667
www.thecostellocenter.com

Welcome! The following information is presented to you with the belief that a clear understanding of the business aspects of our relationship greatly facilitate the relationship between counselor and client. Signing your initial next to each numbered item indicates that you have read and understand all intake documents and information.

Please read and initial each statement:

___ 1. ***CONFIDENTIALITY***: I have read and signed the NOTICE OF PRIVACY PRACTICES. I understand that all information obtained in the course of our relationship is fully confidential. I understand that my signature is required as consent to release part or all of the information. Exceptions to this include instances when 1) the client is a clear danger to (a) themselves or (b) others and/or, 2) that client is a minor (under the age of 18) and either reports, or it is suspected that s/he has been a victim of physical or sexual abuse or neglect.

___ 2. ***EMERGENCIES***: In the event of an emergency, please contact 911 or go to your nearest Emergency Room.

___ 3. ***TELEPHONE CALLS***: If you need to speak with your counselor at a time other than your scheduled session, call the office at 727-345-2667 and leave a message with the receptionist or on the voicemail. If possible, your therapist will respond to your call during his/her normal business hours. There is a charge for any telephone consultation between scheduled sessions that is greater than 5 minutes in length.

___ 4. ***EMAILS***: I have read, understand and signed the email policy.

___ 5. ***LENGTH OF SESSION***: Unless an extended session is scheduled in advance, your session is 45 to 50 minutes in length beginning at your appointed time and concluding 45 to 50 minutes later. Therefore it is to your benefit to arrive a few minutes in advance of your appointment time. Since other appointments are scheduled after yours, the session must end 45 to 50 minutes after the appointment time, regardless of your time of arrival (full fee for the session will be charged).

___ 6. ***FEES AND PAYMENT***: Even though your insurance company carrier may pay all or part of any psychotherapy or psychometric (testing) charges you incur, you are responsible for **payment at the time of each visit** (see 'Insurance' below). Outstanding balances are sent for legal collection after 30 days, therefore adding a $50.00 fee to the total balance due. A $20.00 charge will be levied on all checks returned by a bank for any reason.

___ 7. ***INSURANCE***: We do not accept insurance. It is your responsibility to determine the limits and scope of your insurance coverage. It is also your responsibility to obtain preapproval or precertification form your insurance carrier. Your weekly paid receipt is generally sufficient for proper claims handling by your carrier and one will be provided at each visit.

___ 8. ***CANCELLATIONS AND MISSED APPOINTMENTS***: When an appointment is scheduled, that time is reserved for you. If the appointment is missed or canceled without sufficient notice, this time is not able to be used. Therefore, sessions must be canceled a minimum of 24 hours in advance or the full fee for that session will be charged. Please note that most insurance carriers do not cover missed appointments.

___ 9. ***TERMINATION***: The ending of the therapeutic relationship is an important process and should be discussed during your regular session. If we have not heard from you in 90days, without it being planned by a counselor, our records will indicate that you have been discharged. However, if at any time you choose to return, you are welcome to.

___ 10. ***YOUR RECORDS*** will be kept by this office for a period of five (5) years after discharge, at which time they will be shredded.

___ 12. ***ANCILLARY SERVICES*** the Psychiatrist, Counselors, Coaches, CAP and Tutors are independent consultants that offer additional services at The Costello Center. They are not employees of The Costello Center.

We trust that your involvement with our practice will be helpful to you. If you have any questions regarding these arrangements or other aspects of our relationship, please discuss them during your regular visit.

Please print and sign to certify that you read, understand, and have been given a copy of this document (upon request).

_____	_____	_____
Client Name (print)	Client signature	Date

If a parent is signing on behalf of a client under 18, please sign below:

_____	_____	_____
Parent/Guardian Name (print)	Signature of Parent/Guardian	Date

Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse patient. (42 C.F.R. 2.32)